



LONG TERM CARE

NEWSLETTER

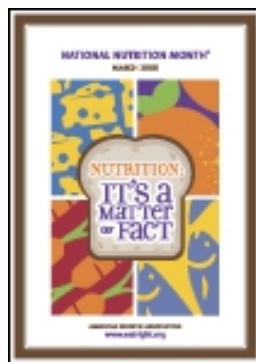
Indiana State Department of Health

ISDH Long Term Care
Newsletter
Issue # 08-06
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In Today's Issue:

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National Nutrition Month® — March 2008



National Nutrition Month® is a nutrition education and information campaign created by the American Dietetic Association (ADA). The campaign is designed to focus attention on the importance of making informed food choices and developing sound eating and physical activity habits. National Nutrition Month also promotes ADA and its members to the public and the media as the most valuable and credible source of timely, scientifically-based food and nutrition information.

This is a wonderful opportunity for health care facilities to focus on nutrition and physical activities. The American Dietetic Association [Website](http://www.eatright.org) provides numerous ideas and resources for the month.

ISDH Long Term Care Leadership Conference

The 3rd Indiana State Department of Health Long Term Care Leadership Conference is scheduled for March 18, 2008. The conference will be from 8:30 – 4:00 at the Indiana Convention Center in downtown Indianapolis. We are inviting each comprehensive care long term care facility to send two people. ISDH long term care surveyors will be attending the conference. The agenda for the conference is as follows:

7:30 – 8:30 Conference Registration

A continental breakfast will be available for conference participants.

8:30 – 8:45 "Welcome and Announcements"

Speaker: Terry Whitson, Assistant Commissioner, Indiana State Department of Health.

8:45 – 9:45 "A Restraint Free Future"

Speaker: Beryl D. Goldman, Ph.D., MS, RN, NHA is Director of Outreach for Kendal Outreach, LLC, Kennett Square, Pennsylvania and Director of the Pennsylvania Restraint Reduction Initiative.

Topic: Ms. Goldman will provide an overview of the importance of reducing and eliminating restraints, achieving

positive outcomes and maintaining the highest practicable well-being for the residents. She will discuss how the practice of caring for the long term care resident can change as a result of a restraint free environment.

10:00 - 10:30 "Regulatory Overview of Restraints"

Facilitator: Burton Garten, Director of Program Development, ISDH

Speakers: Sue Hornstein, Director of Long Term Care, ISDH

Judi Navarro, Surveyor Supervisor, ISDH

Kim Rhoades, Survey Manager, ISDH

Susie Scott, Informal Dispute Resolution Program Manager, ISDH

Topic: The panel will discuss the regulatory requirement of 42 CFR 13(a) which states: The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Specific cases will be discussed and analyzed.

10:30 – 11:45 "Creating a Restraint Free Environment"

Speaker: Joanne Rader, RN, MN, FAAN is an independent consultant and Associate Professor of Gerontological and Mental Health Nursing at the Oregon Health Sciences University School of Nursing.

Topic: Ms. Rader will discuss the key elements, assessment, individualized care, and interventions, necessary to create a restraint free environment. Topics will include modifying the environment, recognizing behavior symptoms as unmet needs, developing acceptable outcomes, selecting appropriate approaches and interventions in order to reduce restraints.

11:45 – 1:00 Lunch

Lunch will be provided for conference participants.

1:00 –2:30 "Creating a Restraint Free Environment" (Continued)

Speaker: Joanne Rader, RN, MN, FAAN

2:45 – 4:00 "Managing a Resident Drug Therapy and Behavior"

Speakers: Gerald H. Roesener, RPh, CGP, FASCP is President of the Indiana Academy of Long-Term Care Pharmacists and works with Cornerstone Pharmacy Services.

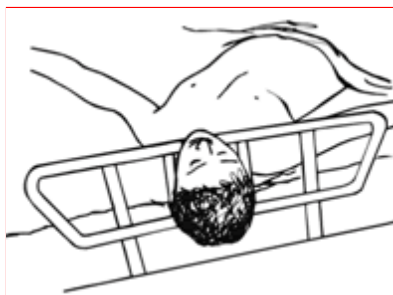
John Wernert, MD is a past President of the Indianapolis Medical Society and practices Geriatric Psychiatry in central Indiana.

Topic: Mr. Roesener and Dr. Wernert will discuss how recognizing the importance of coordinating the medication regime with the individualized resident behavior management program. This coordinaton is intended to result in positive resident outcomes and the elimination of unnecessary chemical restraints.

4:00 Adjourn

More information on this conference is available on the ISDH Website. For information and electronic registration, go to <http://www.in.gov/isdh/about/events.html>.

Bed Rail Entrapment



There recently was a tragic death of a resident in an Indiana nursing home involving bed rail entrapment. Facilities need to be checking the bed rails being used for residents. Please be especially observant of the rails on any of the beds in the facility that have more than 4 3/4 inches between the bars. Please review the guidance provided from CMS on F323 and from the FDA website for information about entrapment in hospital bed rails.

F323 Guidance

Regardless of the purpose for use, bed rails (also referred to as "side rails," "bed side rails," and "safety rails") and other bed accessories (e.g., transfer bar, bed enclosures), while assisting with transfer and positioning, can increase resident safety risk. Bed rails include rails of various sizes (e.g., full length rails, half rails, quarter rails) that may be positioned in various locations on the bed. In 1995, the FDA issued a Safety Alert entitled "Entrapment Hazards with Hospital Bed Side Rails."¹⁸

Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. that may cause them to move about the bed or try to exit from the bed. The timeliness of toileting, appropriateness of positioning, and other care-related activities can contribute to the risk of entrapment.¹⁹

Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Technical issues, such as the proper sizing of mattresses, fit and integrity of bed rails or other design elements (e.g., wide spaces between bars in the bed rails) can also affect the risk of resident entrapment.¹⁹

18. US Dept. of Health and Human Services, Food and Drug Administration (August 23 1995). FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails.

19. US Dept. of Health and Human Services, Food and Drug Administration, Hospital Bed Safety Workgroup. (April 2003), Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings. Retrieved November 11, 2005 from <http://www.fda.gov/cdrh/beds/>.

Dimensional Limits for Identified Entrapment Zones 1-4

[The following is an excerpt from the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment - Guidance for Industry and FDA Staff (Issued March 10, 2006). Click [here](#) to link to the entire document and Appendices referred to below.]

FDA is recommending dimensional limits for zones 1 through 4 at this time because we believe the majority of the entrapments reported to FDA have occurred in these zones. We based these recommended limits upon the body parts entrapped in these individual zones identified through adverse event reports and entrapment scenarios described in the reports. A summary table (Table 3) of the hospital bed dimensional limit recommendations appears on page 21 at the end of this section.

The Hospital Bed Safety Workgroup developed and validated test methods to measure and assess gaps or openings in zones 1-4 of hospital bed systems, reprinted in Appendix F. As a member of the Hospital Bed Safety Workgroup, the

Federal Drug Administration (FDA) participated in the development and validation of these test methods. FDA recommends these test methods as an acceptable approach for assessing hospital bed gap sizes in accordance with the dimensional limitations described below. The test methods and tool used to conduct these tests are available through the Hospital Bed Safety Workgroup (see Appendix B). If an alternate approach is used to assess gap sizes, FDA recommends that the dimensional limits used in any alternative approach be at least as stringent as the ones described below.

Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The Hospital Bed Safety Workgroup and International Electrotechnical Commission (IEC) recommend that the space be less than 120 mm (4 3/4 inches), representing head breadth.

IHAN Health Alert

The following alert was issued by the Indiana Health Alert Network. The alert originated from the CDC Health Alert Network, Friday, February 29, 2008, 14:10 EST (02:10 PM EST) CDCHAN-00271-2008-02-29-ADV-N.

Influenza Antiviral Use for Persons at High Risk for Influenza Complications or Who Have Severe Influenza Illness

CDC is alerting clinicians to be fully aware of the potential benefits of influenza antiviral medications during this influenza season.

Summary:

Recent surveillance data indicate that many communities are reporting substantially increased influenza activity. **This CDC Health Advisory is intended to re-emphasize the importance of considering antiviral medications for use in the treatment or prevention of influenza. The two prescription antiviral medications recommended for treatment or prevention of influenza include oseltamivir (Tamiflu®, Roche Laboratories, Nutley, NJ) or zanamivir (Relenza®, GlaxoSmithKline, Research Triangle Park, NC). These antiviral medications are also known as neuraminidase inhibitors.** Recent studies suggest a considerable protective effect against complications associated with influenza when neuraminidase inhibitors are used for treatment. These benefits include reducing the risk of death among older adults hospitalized with laboratory-confirmed influenza. Because high levels of resistance to adamantane antiviral medications (rimantadine and amantadine) continue to be observed among circulating influenza A viruses, adamantanes are not recommended for treatment or prevention of influenza.

Background:

During this influenza season, a small increase in the number of influenza viruses resistant to oseltamivir has been observed in the United States. Among the 471 influenza A and B viruses tested during the 2007–08 influenza season to date, 27 (5.7%) have been found to be resistant to oseltamivir, compared with 0.7% during the 2006-07 season. All of the oseltamivir-resistant viruses have been influenza A viruses of the H1N1 subtype; 8.7% of the 310 H1N1 viruses tested are resistant to oseltamivir. No resistance to oseltamivir has been observed among the 161 influenza A (H3N2) and influenza B viruses tested to date, and no antiviral resistance to zanamivir has been detected in any subtype.

Recommendations:

Given the low level of overall resistance to oseltamivir among circulating influenza viruses, the finding of resistance only in influenza A (H1N1) viruses, and no resistance to zanamivir, **neuraminidase inhibitor medications continue to be recommended for the treatment and chemoprophylaxis of influenza.** Antiviral treatment should begin within 48 hours of symptom onset if possible, but treatment should still be considered for persons who present more than 48 hours after illness onset if they have severe influenza illness or are at higher risk for severe complications from influenza. **Oseltamivir is approved for treatment and prevention of influenza for persons 1 year and older, while zanamivir is approved for treatment of persons 7 years and older and prevention of influenza in persons 5 years and older.** Enhanced surveillance for detection of oseltamivir-resistant influenza viruses is ongoing, and antiviral usage recommendations will be revised to account for changes in antiviral resistance trends as needed. Influenza A viral isolates from affected persons in institutional outbreaks should be subtyped. Health care providers should contact their local or state public health department for assistance when an outbreak of influenza in an institutional setting (e.g., a long-term care facility) occurs. State health departments should consult with CDC about the need for antiviral resistance testing when influenza A (H1N1) viral isolates are obtained from outbreaks in institutional settings.

In some communities, circulating influenza virus strains during this influenza season are antigenically different from those contained in current influenza vaccines. Preliminary results from a rapid assessment of vaccine effectiveness suggest that currently available influenza vaccines provide some protection against influenza virus infection requiring medical care. However, the level of protection is likely to be lower than what is observed in seasons in which the vaccine strains are closely matched to circulating influenza virus strains. When influenza vaccine effectiveness is reduced, clinicians should be aware of the potential for appropriately vaccinated persons to develop influenza despite vaccination.

Because approximately 2 weeks is required to develop an optimal immune response to influenza vaccination, use of neuraminidase inhibitors for prevention of influenza during a confirmed influenza institutional outbreak should be considered for persons at higher risk for influenza complications and who were vaccinated within the previous 2 weeks. Persons who were vaccinated more than two weeks before a suspected influenza virus exposure, but who are less likely to develop protective immunity after vaccination (e.g., persons in long-term care facilities or persons with immunosuppression), can be considered for antiviral chemoprophylaxis when local influenza surveillance data indicate that influenza activity is high.

Clinicians should consider whether to recommend influenza antiviral treatment based on the severity of the patient's illness, the time since illness onset, local influenza surveillance data and influenza test results. Rapid diagnostic tests for influenza have good specificity, but are only moderately sensitive. Positive rapid tests are generally reliable when influenza activity is high in a community and are useful in deciding whether to initiate antiviral treatment. Negative rapid test results are less helpful in making treatment decisions. When local influenza activity is high, persons with severe respiratory symptoms or persons with acute respiratory illness who are at higher risk for influenza complications should still be considered for influenza antiviral treatment despite a negative rapid influenza test unless illness can be attributed to another cause. As reported in a previous HAN, persons with severe influenza illness should also be assessed for invasive bacterial co-infection, and appropriate antimicrobial therapy directed at potential bacterial pathogens, such as methicillin-resistant *Staphylococcus aureus*, might be necessary.

To reduce the substantial burden of influenza in the U.S., **CDC continues to recommend a three-pronged approach: influenza vaccination, use of neuraminidase inhibitor antiviral medications when indicated for treatment or prevention, and use of other measures to decrease the spread of influenza, including promotion of hand hygiene, respiratory hygiene, cough etiquette, and staying home from work and school when ill.** Clinicians in communities experiencing increased influenza activity should consider prescribing the neuraminidase inhibitor antiviral medications oseltamivir and zanamivir for the treatment of influenza patients or for prevention of influenza when indicated for institutional influenza outbreaks or for persons at high risk for complications from influenza who have contraindications to influenza vaccination.

For more information, please see the CDC website: <http://www.cdc.gov/flu/professionals/antivirals/>

If you have any questions about this Health Advisory, please call the Influenza Division, Epidemiology and Prevention Branch at 404-639-3747.

After normal business hours, contact CDC's duty officer through the CDC Director's Emergency Operation Center (DEOC) at (770) 488-7100.



That is all for this week. I look forward to seeing you at the Leadership Conference on March 18.

Terry Whitson
Assistant Commissioner
Indiana State Department of Health